

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-029882

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7499

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED JUL 25 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN

St. Louis

Length of stay in lb
OR
TOWN

44 yrs.

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

Homer G. Phillips

Inside Limits
Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

c. CITY
OR
TOWN St. Louis

Inside Limits
Yes ☐ No ☐

d. STREET
ADDRESS (If outside, give location)
5525A Wells

Reside on Farm
Yes ☐ No ☐

3. NAME OF DECEASED
(Type or print)

First Edith

Middle

Last Duke

4. DATE
OF
DEATH

Month 7

Day 17

Year 63

5. SEX

Fem.

6. COLOR OR RACE

Negro

7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐

8. DATE OF BIRTH

10/2/01

9. AGE (last birthday)

61

IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.

9 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

Yalobushia Co., Miss.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Jim Johnson

13b. MOTHER'S MAIDEN NAME

Adaline Crump

14. NAME OF HUSBAND OR WIFE

Thomas Duke

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Thomas Duke, 5525a Wells

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

Unket.

DUE TO (b)

Cerebral Arteriosclerosis

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (c)

Generalized Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days

332x

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☐

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURY

Hour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

7-16-63

5:40 P.

7-17-63

and last saw her alive on

7-17-63

Death occurred at

5:40 P.

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Doctor or Nurse)

22b. ADDRESS

2601 N. Whittier

22c. DATE SIGNED

7-19-63

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Removal

23b. DATE

7/23/63

23c. NAME OF CEMETERY OR CREMATORY

National Cemetery

23d. LOCATION (City, town, or county)

Jefferson Barracks, Mo.

(State)

24. FUNERAL DIRECTOR

ADDRESS

Charles J. Gates, Jr., 4107 Finney

25. DATE RECD. BY LOCAL REG.

JUL 22 1963

26. REGISTRAR'S SIGNATURE

Head Smith, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4580

P.O. Address 4107 Finney

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.